

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-018138**

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

**318**

Primary Registration District No.

**1003**

Registrar's No.

**3887**

**FILED APR 17 1963**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>		c. CITY OR TOWN <b>Riverview</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>CHRISTIAN HOSPITAL</b>		d. STREET ADDRESS <b>247 Coburg Dr</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>RIECHMANN</b> Last <b>RIECHMANN</b>		4. DATE OF DEATH Month <b>Apr.</b> Day <b>4</b> Year <b>1963</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6/27/76</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>	9. AGE (last birthday) <b>86</b>
11. BIRTHPLACE (City and state or country) <b>St. Louis Co., Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>William Riechmann</b>		13b. MOTHER'S MAIDEN NAME <b>Caroline Borcharding</b>	
14. NAME OF HUSBAND OR WIFE <b>Ellen Riechmann</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of) <b>no</b>	
16. INFORMANT <b>Esther Neustadt, 247 Coburg Dr.,</b>		17. ADDRESS <b>Esther Neustadt, 247 Coburg Dr.,</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> DUE TO (b) <b>Cerebral Thrombosis</b> DUE TO (c) <b>Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Myocardial Insufficiency</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>3 days</b> <b>10+ yrs.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour <b>5:30</b> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY	
20g. STATE		21. I attended the deceased from <b>1957</b> to <b>Apr. 1963</b> and last saw him alive on <b>2 Apr. 1963</b> Death occurred at <b>5:30 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <b>Leonard J. Kopp, M.D.</b>		22b. ADDRESS <b>1917 N. Hanley Rd. St. Louis</b>	
22c. DATE SIGNED <b>5 Apr 1963</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	
23b. DATE <b>4/8/63</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Salem Lutheran Cem</b>	
23d. LOCATION (City, town, or county) <b>St. Louis Co., Mo.</b>		24. FUNERAL DIRECTOR <b>Diedrich Funeral Home, 8319 Halls Ferry</b>	
25. DATE RECD. BY LOCAL REG. <b>APR 5 1963</b>		26. REGISTRAR'S SIGNATURE <b>Road Smith, M.D.</b>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

USE BLACK INK

OR

TYPEWRITER RIBBON

VS 300  
Rev. 4/59

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**240373**

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**56**

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

*Harvey Stahl*

Licensed Embalmer No. \_\_\_\_\_

*4596*

P. O. Address \_\_\_\_\_

*St. Louis, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.